drugs. However, although it is not possible to prove this the responsibility of fluothane for the jaundice seems convincing. While many drugs have been indicted as causes of liver damage, this patient received no other agent even suspected of hepato-toxicity. Intra-abdominal operation near the liver and antibiotics have also been blamed; however, this lady was in hospital for immediate and delayed suture of her ulnar nerve, and antibiotics were not administered later than seven weeks before the onset of jaundice.

I would like to thank Dr. P. B. Newcomb for his kind permission to report this case.

—I am, etc.,

Hackney Hospital, London E.9. J. ROBINSON.

Chlorphentermine

SIR,—I must protest at the reference made to chlorphentermine ("lucofen") (October 5, p. 853) in regard to the inference that chlorphentermine, while having an appetite suppresant action, also produces central nervous stimulation and is not satisfactory. We too have noticed amphetamines in this respect.

Chlorphentermine has been widely prescribed in this country and abroad and there have been no reports of nervous stimulation. This is corroborated by a number of publications, of which the following examples are listed.[1-3]—I am, etc.,

D. D. H. CRAIG.
William R. Warner & Co. Ltd., Eastleigh, Hants.

REFERENCES

1 Levin, J., Trafford, J. A. P., Newland, P. M., and Bishop, P. M. F., *Practitioner*, 1963, 191, 65.
2 Mune, O., and Pallesen, A. E., *Ugeskr. Laeg.*, 1960, 122, 605.
3 General Practitioner Research Group Report, No. 12, *Practitioner*, 1961, 187, 216.

*** We have shown this letter to our expert contributor, who replies as follows: "Although absence of stimulating effects was noted in the reports on chlorphentermine ("lucofen") quoted above, claims for any superiority over amphetamine or dexamphetamine must await adequate comparative trials, as similar claims for other anorectic drugs have often subsequently been shown to depend on the use of less effective dosage. It must also be noted that evidence of habituation or addiction may only appear after several years of general experience with such drugs."—ED., *B.M.J.*

Amiphenazole and Bronchitis

SIR,—The persistent bludgeonings which we suffer at the hands of advertisers have mercifully blunted my sensibilities, so that I usually find it a painless matter to consign automatically to the waste-paper basket all but the small informative fraction of the advertising matter for pharmaceutical products which comes through my letter-box. But I am moved to protest by an advertisement in the form of a news-sheet which caught my eye, with banner headlines on the first page, "Major Breakthrough in Chronic Bronchitis." Wondering whether I had missed something important in my own field of interest, I read on, to find that the drug to which it referred was none other than amiphenazole, under the trade name "daptazole." We have been familiar with the actions of this drug in chronic bronchitis for several years; as far as I am concerned, since my friend Dr. Tom Simpson drew my attention to it about five years ago. Publications by him and by Dr. G. M. Little were quoted in the advertisement. The observations of Dr. Simpson and Dr. W. Hawkins were recorded briefly in a letter in your columns[1]; they concerned patients with ventilatory insufficiency and carbon-dioxide retention, in whom large doses of amiphenazole intravenously at hourly intervals were found to "stimulate the respiratory centre even when depressed by oxygen." It was also noted that effective doses made the patient cough, and caused nausea which helped to clear the sputum. Dr. Little's[2] work also concerned patients who were gravely ill with exacerbations of ventilatory insufficiency, and his moderate conclusion was a suggestion that amiphenazole might have a place in the treatment of carbon-dioxide retention. I hope that all who perused this document did so with an alert critical faculty and so perceived the extremely tenuous connexion between these quoted observations and the sweeping claims that "by prescribing this new (*sic*) drug the doctor can not only ease the burden of the chronic bronchitic, but postpone or prevent his eventual hospitalization."

So far as I know, there is no evidence that amiphenazole is of the slightest value in the management of the ambulant chronic bronchitic.—I am, etc.,

J. G. SCADDING.
Institute of Diseases of the Chest, London S.W.3.

REFERENCES

1 Simpson, T., and Hawkins, W., *Brit. med. J.*, 1959, 1, 508.
2 Little, G. M., ibid., 1962, 1, 223.

Cyclophosphamide

SIR,—Your special correspondent reporting on the symposium on cyclophosphamide held at the Royal College of Surgeons on October 4, 1963 (November 9, p. 1189), quotes me as follows:

"Dr. G. H. Fairley (St. Bartholomew's Hospital) felt it was too early to draw any conclusions on 62 cases of Hodgkin's disease that had been treated with cyclophosphamide over the past three years because in only eight of these had it been the first form of treatment."

This is incorrect and misleading. Since early cases of Hodgkin's disease are usually treated with radiotherapy it is not surprising that cyclophosphamide was the first form of treatment in only eight of our 62 cases. What I in fact presented was an analysis of the results of treatment when cyclophosphamide was used for the first time regardless of previous radiotherapy or chemotherapy; in most cases cyclophosphamide was the first form of *chemotherapy* used. To say that I felt it was too early to draw any conclusions is quite untrue, as the results showed that cyclophosphamide, like other nitrogen mustards, is a most valuable drug in the treatment of patients with Hodgkin's disease and is likely to prove effective the first time it is used.—I am, etc.,

G. HAMILTON FAIRLEY.
St. Bartholomew's Hospital, London E.C.1.

Apparatus for Oxygen Administration

SIR,—As Drs. D. C. Flenley, D. C. S. Hutchison, and Professor K. W. Donald (November 2, p. 1081) have clearly shown, the performance of the current production version of the Venturi mask is not satisfactory. We too have noticed this and I would like to amplify their observations.

The current mask differs from the prototype in having a shorter barrel and a narrower (and therefore higher velocity) additional oxygen nozzle. On returning to the dimensions of the prototype we have, however, found that the performance, although better, is still unsatisfactory. It seems that the measurements I reported in 1960[1] were misleading because, not having a rapid oxygen analyser, I used a technique of multiple sampling which gave only an average concentration in the mask. We are now able to explore the whole air-stream using a mass spectrometer which gives a virtually instantaneous measurement of oxygen concentration. This instrument has shown us that it is difficult to eliminate regional variations due to inadequate mixing in a mask with two oxygen sources. In view of the other disadvantages of this mask, such as the need for a double regulator, its lack of robustness, and its cost, we have suggested to the makers that it be replaced.

We are developing other approaches to the problem. The first to reach production is a single-concentration single-nozzle Venturi mask ("ventimask," Oxygenaire), which can be used with any regulator and is sufficiently inexpensive (7s. 6d) to be regarded as disposable. The concentration delivered by this mask is intended to be 27% at an oxygen flow of 4 l./min. We have analysed the concentration in six masks taken at random from stock. At an oxygen flow of 4 l./min. the observed concentration was 26.6% (S.D. 0.51); on reducing the oxygen flow to 2 l./min. the concentration fell by 0.15% (S.D. 0.27), and on increasing the flow to 8 l./min. the concentration rose by 0.45% (S.D. 0.26). There was little variation in composition